State of Illinois
Department of Human Services - Division of Developmental Disabilities

BED HOLD EXTENSION REQUEST FORM

This form is to be completed in accordance with the Department's policy on Bed Hold for adults and children in residential settings. Bed Hold must be requested by the residential provider when an individual terminates from 60D CILA for consideration of payment for any days beyond the person's day last reported present in 60D CILA. Bed Hold requests are required if the person is POS funded and absent for more then 60 CUMULATIVE days. The Residential Provider Agency completes and forwards the Bed Hold Extension Request to your Individual Service Coordination (ISC) Agency. Please type or print legibly.

Last Name of Person Receiving Residential Services _____ First Name _____ MI ____ Social Security Number _____

Residential Provider Agency Name _____ Agency Number _____ Agency FEIN Number _____

Agency QMRP/Contact Person _____ Phone Number _____ Extension _____

Please Identify the DDD Region where this person receives residential services:

DDD REGION: ☐ Northwest ☐ Central ☐ Metro-No. Suburbs ☐ Metro Chicago
☐ Northcentral ☐ South ☐ Metro-So. Suburbs

ISC Agency _____ ISC Agent Contact Person _____ Phone Number _____ Extension _____

We anticipate this person ☐ will ☐ may ☐ will NOT return to residential services at our agency after this bed hold.

DDD funds this person through: (check only one) ☐ 60D CILA ☐ 17D CGH ☐ 19D CCI ☐ 67D/E/O CLF

This person's bed hold extension is requested because:

☐ "C" Convalescent Care at a NF ☐ "H" Hospital (Medical/Psych) ☐ "I" Incarceration
☐ "F" Visit to Family Home/Friends ☐ "S" SODC Admission (Facility Name): _____

If POS funded, please complete the section below for this request

Has your agency previously submitted a Bed Hold request for this person during this fiscal year? ☐ Yes ☐ No

Total CUMULATIVE Bed Hold days approved by DDD year-to-date for this fiscal year: _____ (number of days)

Total number of additional Bed Hold Extension days requested at this time _____

New total of cumulative approved and additional requested Bed Hold Days _____

The new total of CUMULATIVE and requested Bed Hold days will end on: _____ , 20____

If CILA (60D) funded, please complete the section below for this request

Date this person was last present in the CILA home: _____ , 20____

Your agency MUST attach an explanation for the following: (60D Bed hold Requests missing this information will be denied)

1. The reason(s) why this person had to leave 60D residential services resulting in this person's termination.
2. Your agency's involvement to facilitate this person's return to residential services at your agency.

DHS - DDD staff will complete the section below

This Bed Hold request is ☐ Approved through, or ☐ Denied. Stop funding effective: _____ , 20____

Reason for denial:

DDD Staff Signature _____ Printed DDD Staff Name _____ Date _____